April 2001

This distribution contains change pages for patch WV*1*14 of the Women's Health 1.0 user manual (Revised February 2000).

The following documentation change pages should be inserted before these replacement pages:

File Name:	Patch:
WV_1_P9_UM.PDF	WV*1*9
WV_1_P10_UM.PDF	WV*1*10
WV_1_P11_UM.PDF	WV*1*11

Patch WV*1*14 pages:

Replace Pages:	With Pages:
iii-iv	iii-iv
2.1-2.2	2.1-2.2
2.17-2.18	2.17-2.18
4.1-4.52	4.1-4.52
5.1-5.2	5.1-5.2
5.15-5.18	5.15-5.18
6.1-6.2	6.1-6.2
8.1-8.10	8.1-8.10
AB.1-AB.4	AB.1-AB.4
GL.1-GL.6	GL.1-GL.6
IN.1-IN.2	IN.1-IN.2

Remove Pages:
2.23-2.24

Add Pages:
AC.1-AC.2

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Chapter 2 File Maintenance Menu

WV MENU-FILE MAINTENANCE

File Maintenance Menu

Several features of Women's Health can be customized by the ADPAC. These features include such items as the text of form letters, the types of notifications and their synonyms, how and when letters get printed, several defaults relating to dates, and options that appear on some menus.

All of these setup options are located under the File Maintenance Menu of the Manager's Functions menu. It is recommended that the ADPAC examine all of the options listed in this section before utilizing the software for live patient data. Periodically, these options should be re-examined for the purpose of fine tuning the software to the needs of the site.

After customizing your maintenance files, you may wish to run the option Automatically Load Patients [WV AUTOLOAD PATIENTS] to initially populate your WV Patient (#790) file. For more details concerning this option please refer to the option description under the Automatically Load Patients option in this chapter.

Also, you may wish to run the option Import Radiology/NM Exams [WV IMPORT RAD/NM EXAMS] to initially populate your WV Procedure (#790.1) file with mammograms performed recently at your facility. You may automatically add mammograms performed within the last three years. For more details concerning this option please refer to the option description under the Import Radiology/NM Exams option in this chapter.

In the menu on the next page, the top group of options relates to notifications, the middle group addresses package-wide parameters, and the bottom group relates to procedures and their results.

Menu Display:

```
Select OPTION NAME: WV MENU-FILE MAINTENANCE          File Maintenance Menu
```

```
WOMEN'S HEALTH:        *  FILE MAINTENANCE MENU  *        HINES DEVELOPMENT
                       ==========================


AEP     Add/Edit a Notification Purpose & Letter
PPL     Print Notification Purpose & Letter File
ESN     Edit Synonyms for Notification Types
OUT     Add/Edit Notification Outcomes
ESP     Edit Site Parameters
CM      Add/Edit Case Managers
TR      Transfer a Case Manager's Patients
AUTO    Automatically Load Patients
RAD     Import Radiology/NM Exams
PRD     Print Results/Diagnosis File
ESR     Edit Synonyms for Results/Diagnoses
PSR     Print Synonyms for Results/Diagnoses
EDX     Edit Diagnostic Code Translation File
PDX     Print Diagnostic Code Translation File
RS      Add/Edit to Referral Source File
```

NOTE: The option Add Sexual Trauma Data to MST Module was added to this menu by patch WV*1*11 in June 2000, and then this option was removed by patch WV*1*14 in April 2001.

WV PRINT RES/DIAG FILE

Print Results/Diagnosis File

[1]For each procedure type in women's health, only certain results or diagnoses may be selected. The Print Results Diagnosis File option displays results/diagnoses information in three lists within the report output.

The first listing displays the procedure types alphabetically and includes the results/diagnoses associated with each procedure type. The priority and normal value for each result/diagnosis are displayed.

The second listing displays the results/diagnoses sorted by priority. The priority and normal value for each result/diagnosis are displayed.

The third listing displays results/diagnoses sorted alphabetically. The priority, normal value and procedure type associated with the result/diagnosis are displayed.

These results/diagnoses correspond with the Bethesda Classification system for PAP smears and the American College of Radiology for mammograms. Results/diagnosis data is stored in the WV Results/Diagnosis (#790.31) file.

Report Description:

Procedure:
[2]This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure Type (#790.2) file.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Priority:
This field stores an arbitrary number used to prioritize the results or diagnosis term. The range is from 1-90 with 90 being defined as normal or no results, and 1 being the highest priority.

Normal:
This field tells whether the results of the procedure were normal or abnormal. This information is used in autoqueueing normal result letters.

[3]**Associated Procedures:**
This field displays the name of the procedure associated with the result/diagnosis.

---

[1] Patch WV*1*14 April 2001 Description changed
[2] Patch WV*1*14 April 2001 Field description changed
[3] Patch WV*1*14 April 2001 New field

WV EDIT RES/DIAG SYNONYMS

Edit Synonyms for Results/Diagnoses

You may enter a synonym for each procedure type result/diagnosis. The synonym will allow the result/diagnosis to be called up by typing only a few unique characters. Synonyms should be unique and less than 6 characters. For example, 'C1' might be used for CIN I/mild dysplasia; 'C2' for CIN II/moderate dysplasia; 'C3' for CIN III/severe dysplasia, and so on. Each procedure type diagnosis or result may have up to two synonyms. Results/diagnosis data is stored in the WV Results/Diagnosis (#790.31) file.

Field Descriptions:

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Synonym 1:
This field contains a 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

Synonym 2:
This field contains an additional 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

Chapter 4 Patient Management Menu

WV MENU-PATIENT MANAGEMENT

Patient Management

The Patient Management Menu is divided into three groups of options: the patient related options, the procedure related options, and the notification related options.

The patient related options deal mainly with managing patients. The procedure related options deal more directly with the adding, editing and printing of procedures. The notification related options deal mostly with the adding, editing and printing of notifications.

Menu Display:

```
Select OPTION NAME: WV MENU-PATIENT MANAGEMENT          Patient Management

   WOMEN'S HEALTH:      *  PATIENT MANAGEMENT MENU  *       HINES DEVELOPMENT
                        ============================


   [1]PC     Edit/Print Patient Case Data
   PP     Patient Profile
   FS     Print Patient Demographic Info (Face Sheet)
   BD     Browse Patients With Needs Past Due
   LAB    Save Lab Test as Procedure
   AP     Add a NEW Procedure
   EP     Edit a Procedure
   HS     Health Summary
   BP     Browse Procedures
   PR     Print a Procedure
   HIS    Add an HISTORICAL Procedure
   RA     Add a Refusal of Treatment
   RE     Edit a Refusal of Treatment
   AN     Add a New Notification
   EN     Edit a Notification
   BN     Browse Notifications
   PL     Print Individual Letters
   PQ     Print Queued Letters
```

NOTE: The option MST Status Add/Edit was added to this menu by patch WV*1*11 in June 2000, and then this option was removed by patch WV*1*14 in April 2001.

[1] Patch WV*1*6 May 1999 Health Summary option added

WV EDIT PATIENT CASE DATA

Edit/Print Patient Case Data

This option allows you to add a new patient and her case data to the Women's Health register. It also allows you to edit the case data of patients already in the register. When you add or edit a patient's case data, you will be presented with the 'Edit Patient Case Data' screen.

The fields in the top third of the screen (patient name, address, SSN, and phone number) are editable only through the PIMS Registration module. Patient data is stored in the WV Patient (#790) file.

Field Descriptions:

These fields appear above the dashed line on every screen:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Street:
This field contains the patients street address.

City/State/Zip:
This field contains the patient's city, state, and zip code.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

SSN:
This field contains the social security number of the patient.

Patient Phone:
This field contains the patient's phone number.

Primary Provider:
This field contains the name of the patient's primary caregiver.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

[1] Patch WV*1*10 April 2000 Include eligibility code in heading

[1]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

These fields appear below the dashed line:

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient. NOTE: All case managers must be entered by the ADPAC under the File Maintenance Menu.

Date Inactive:
This field contains the date on which this patient's record became inactive. ANY date (past, present or future) will cause this patient's data to be excluded from all reports that assess treatment needs (i.e., Snapshot of the Program Today report and Browse Patients with Needs Past Due).

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Tx Due Date:
This field contains the date by which the breast Tx procedure should be completed.

Breast Tx Facility:
The name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Tx Due Date:
This field contains the date when this gynecologic procedure or treatment should be completed.

Cervical Tx Facility:
The name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1] Patch WV*1*14 April 2001 MST appears in heading of the report

PAP Regimen:
This field stores the current PAP regimen for the patient. The regimen appears in an abbreviated form so that it can be listed on several screens where there is limited space. The following abbreviations apply:

symbol	meaning
P	PAP
C	colposcopy
wk	week
m	month
y	year
q	every
pp	postpartum
x2	times 2
x3	times 3
ga	gestation

The abbreviations read much like a prescription. For example, 'Pq6mx2, Pqy' stands for 'PAP every 6 months times 2, then PAP every year (annually)'. Another example, 'P6wkpp, C8-12wkpp' stands for 'PAP at 6 weeks postpartum, then colposcopy 8 to 12 weeks postpartum'.

PAP Regimen Start Date:
This field stores a date on which the patient began or will begin her current PAP regimen.

[1]**CST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Family Hx of Breast CA:
[2]This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister), multiple 1st degree relatives (mother AND sister), personal history, or unknown.

[1] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to CST prompt
[2] Patch WV*1*7 October 1999 Added codes

Notes (WP):
This is a word processing field that stores additional information about the patient and her health care needs.

Currently Pregnant:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

EDC:
This field stores the patient's delivery date or estimated date of confinement (EDC).

DES Daughter:
[1]This field indicates if this patient's mother took diethylstilbestrol (DES) when she was pregnant with this patient. Choices are yes, no, and unknown.

Date of 1st Encounter:
This field contains the date of the patient's first clinic visit. Although a date is automatically stuffed when the Automatically Load Patients [WV AUTOLOAD PATIENTS] option is run, the information can be edited through the Edit/Print Patient Case Data option.

Referral Source:
This field stores information on who referred the patient or how the patient found out about the women's health care services at the facility. This field points to entries in the WV Referral Source (#790.07) file. Additional choices may be added by the facility via the option Add/Edit to Referral Source File.

After exiting the 'Edit Patient Case Data' screen you will be given the opportunity to print the patient's case data to a device.

[1] Patch WV*1*7 October 1999 Added codes

WV PATIENT PROFILE

Patient Profile

This option allows you to list all of the procedures and notifications associated with an individual patient. If you choose the brief format, only the patient's procedures will be listed. If you choose the detailed format, both procedures and notifications, as well as PAP regimen changes and pregnancies will be listed.

The patient's case data is shown above the double-dashed line, while the procedures, their dates, results, and status are shown below. If the device selected for the patient profile is 'Home' (to the screen), a column of numbers will appear to the left of the procedures (and of the notifications in the detailed report). Patient data is stored in the WV Patient (#790) file.

Report Description:

These fields appear above the dashed line, and appear on every page of the report:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

Facility:
This field contains the name of the facility responsible for the women's health care needs of this patient. If the health care facility you wish to select is not available in this file, contact your site manager or ADPAC. Pointer to the Institution (or Facility) (#4) file.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Primary Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

[1]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

[2]**Family Hx of Breast CA:**
This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister), multiple 1st degree relatives (mother AND sister), personal history, or unknown.

[3]**Eligibility Code:**
This field contains the eligibility code of the patient.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

[1] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt
[2] Patch WV*1*7 October 1999 Added codes
[3] Patch WV*1*10 April 2000 Include eligibility code in heading

These fields appear below the dashed line:

Date:
This field contains the date the procedure was performed.

Procedure:
This field displays the abbreviation of the procedure (type) performed on the patient. Pointer to the WV Procedure (#790.1) file.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

The following fields only appear on the detailed report:

PAP Regimen Change:
This is the beginning date of change and the name of the new regimen.

Pregnancy Status:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

Notifications:
This includes the procedure accession number and name associated with the notification, notification outcome, status, purpose and type.

Procedures:
This field includes the Women's Health procedure accession number.

WV PATIENT DEMOGRAPHIC INFO

Print Patient Demographic Info (Face Sheet)

This option allows you to display or print patient demographic information. It provides information such as the patient's address, phone numbers, spouse, emergency contacts and billing information. Patient demographic data is stored in the Patient (#2) file.

Field Descriptions:

Name:
This field contains the name of the patient. It is a pointer to the Patient (#2) file.

SSN:
This computed field displays the patient's social security number from the Patient (#2) file.

Address:
This field contains the address of the patient.

County:
This field contains the name of the county where the patient lives.

Phone:
This field contains the patient's phone number.

Office:
This field contains the patient's office phone number.

Temporary:
This field contains the patient's temporary address, if there is one.

From/To:
This field contains the from/to dates in which the patient lived at the temporary address.

Phone:
This field contains the phone number for the temporary address.

Primary Eligibility:
This field contains the primary benefits eligibility code for this patient.

Other Eligibilities:
This field contains any other benefits eligibility codes for this patient.

Status:
This field contains the eligibility status for this patient.

Discharge Type:
This field contains the type of discharge which the patient received for her most recent episode of military service.

Admitted:
This is the date the patient was admitted to the hospital.

Discharged:
This is the date the patient was discharged from the hospital.

Ward:
This field contains the current ward location on which this patient is residing if an inpatient.

Room-Bed:
This field contains the current room and bed on which this patient is residing if an inpatient.

Provider:
This field stores the name of the provider currently assigned to this patient.

Specialty:
This field contains the treating specialty to which this inpatient is currently assigned.

Attending:
This field contains the name of the attending physician currently responsible for the care of this patient.

Admission LOS:
This field contains the number of days the patient has been in the hospital during the current stay.

Absence Days:
This field contains the number of days the patient has been absent from the hospital.

Pass Days:
This field contains the number of days the patient has been on pass.

ASIH Days:
The field contains the number of days the patient is Absent Sick In Hospital (ASIH).

Currently enrolled in:
This field contains any insurance programs the patient is currently enrolled in.

Future Appointments:
This field contains a list of any future appointments the patient may have.

Remarks:
This field contains any short comments the user may wish to enter about this patient.

WV BROWSE NEEDS PAST DUE

Browse Patients With Needs Past Due

This option allows you to search for and browse through patients whose treatment needs are past due. The five questions that are asked prior to the display allow you to specify the needs, dates, case managers, order of display, and device for the display.

NOTE: It may be useful to select a date at some time in the future, for example, two weeks ahead, in order to anticipate which patients will become delinquent and to act on those cases ahead of time.

If the device selected is 'Home' (to the screen), a column of numbers will appear to the left of the chart numbers.

A patient will not be processed if there is any value (past, present, or future) in the Date Inactive field on the Edit/Print Patient Case Data option screen. Patient needs past due data is stored in the WV Patient (#790) file.

[1]NOTE: When the option is run it checks the Patient (#2) file for a date of death. If there is a date of death, it will be entered as the inactive date in the Women's Health database.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

Treatment Need and Due by Date:
This field contains the name of the current or next procedure or treatment need scheduled for this patient, including the due by date.

Primary Care Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

[1] Patch WV*1*7 October 1999 Date of death as inactive date

[1]**Age:**
This field contains the age of the patient.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

Eligibility Code:
This field contains the eligibility code of the patient.

[1] Patch WV*1*10 April 2000 Include age, veteran, and eligibility code in report

[1]WV SAVE LAB TEST

Save Lab Test as Procedure

This option is used to save lab tests as procedure entries in the Women's Health package. Lab tests for cytology and surgical pathology are passed to the Women's Health package from the Lab package and stored in the WV Lab Tests (#790.08) file. A mail message is sent to the patient's case manager stating a lab test has been released to the Women's Health package. This option allows the user to first view the lab tests in an uneditable screen, then dispose of the lab tests either by 1) adding the lab test data into a Women's Health package procedure, 2) deleting the lab test from the WV Lab Tests file (i.e., don't convert it into a Women's Health procedure), or 3) ignore the lab test for the time being. The lab test can be looked up by requesting provider, lab accession, patient name or SSN, or date of test.

If the user chooses to add the lab test to the Women's Health package, the user is first asked to select a WH procedure type, to associate with the lab test (e.g., PAP Smear). The lab test is saved as a Women's Health procedure in the WV Procedure (#790.1) file. The user is placed in the procedure data entry screen and may edit/close out the procedure entry. The lab report can be viewed again by going into the Reports (WP) field.

The software may provide a default response at the "Select Lab Test Accession #:" prompt. The software checks each entry, if the user is the requesting provider for a test, or the Women's Health case manager for a patient, that entry will be displayed as a default response. A default response is provided until the user has looped through all associated tests or up-arrows out of the option. The user may enter a question mark to see a list of all entries or select any entry to process.

Note: This option can only work if the Lab package patch LR*5.2*231 is installed and the "Import Test from Laboratory" field is set to 'Yes' for the facility in the Edit Site Parameters [WV EDIT SITE PARAMETERS] option.

It is possible that the wrong patient was originally associated with a lab test. When this happens, the Lab package has an option to associate the correct patient with the lab test. The Lab package contains a check that will call the Women's Health package if a lab test is moved from one patient to another. If the lab test was converted into a Women's Health procedure entry the Women's Health package does the following:

1. Disassociates the Women's Health entry from the Lab package entry (i.e., will not delete the Women's Health entry, but will not show the lab results).
2. Changes the Result/Dx of the Women's Health entry to 'Error/disregard'.
3. Sends a mail message to the case manager stating lab results no longer belong to that patient and identify the Women's Health entry. The case manager can then make any additional changes or add notes to the record.

[1] Patch WV*1*6 May 1999 New option

[1]4. If the new patient associated with the lab test is female, then the lab test will be passed to the Women's Health package and stored as a new entry in the WV Lab Test (#790.08) file.

If the results of a lab test are ever edited by the Lab user, and the lab test was saved as a WH procedure entry, the case manager will receive a mail message indicating the lab report has changed. Also, the status of the WH procedure entry will be set to 'Open', and the Complete by (Date) is updated.

[1] Patch WV*1*6 May 1999 New option

WV ADD A NEW PROCEDURE

Add a NEW Procedure

This option allows you to add procedures for patients. The first prompt asks you to select a patient (either by name, or SSN). The second prompt asks you to select a procedure. The possible choices of procedures are listed in the table below:

[1]Breast Ultrasound - BU	LEEP - LP
Clinical Breast Exam - CB	Lumpectomy - LM
Colposcopy Impression (No BX) -CI	Mammogram Dx Bilat - MB
Colposcopy w/Biopsy - CO	Mammogram Dx Unilat - MU
Cone Biopsy - CN	Mammogram Screening - MS
Cryotherapy - CY	Mastectomy - MT
Ectocervical Biopsy - EB	Needle Biopsy - NB
Endocervical Curettage - EC	Open Biopsy - OB
Endometrial Biopsy - EM	PAP Smear - PS
Fine Needle Aspiration - FN	Pelvic Ultrasound - PU
General Surgery Consult - GS	Pregnancy Test - PT
GYN ONC Consult - GY	STD Evaluation - ST
Hysterectomy - HY	Stereotactic Biopsy - SB
Laser Ablation – LA	Tubal Ligation - TL
Laser Cone - LC	Vaginal Ultrasound - VU

The procedure is selected by typing either its name or its abbreviated code, for example, 'PS' will select 'PAP Smear'. (These codes are also used in the accession numbers, for example, 'PS1998-43' will be an accession# for a PAP smear.)

If the procedure is a unilateral mammogram, an additional prompt will ask you to enter 'Left or Right'. If the procedure is a colposcopy w/biopsy, an additional prompt will ask you to select the accession# of the PAP that initiated this colposcopy.

A final prompt asks you for the date of the procedure. At this point the computer checks to see if this procedure has already been entered for this patient on this date. If so, then this would be a duplicate procedure.

Once you have added a valid new procedure, the program will automatically assign the procedure a unique accession# and then proceed to the 'Edit a Procedure' screen. the accession# for a procedure uniquely identifies that procedure for all editing and reporting purposes. Procedure data is stored in the WV Procedure (#790.1) file.

[1] Patch WV*1*7 October 1999 New procedures added

[1]NOTE: When a Radiology/Nuclear Medicine package exam is passed to the Women's Health package, an informational mail message is sent to the WH case manager.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1] Patch WV*1*7 October 1999 Info. message to case manager

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

[1]**Reports (WP):**
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words "AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

[2]**Notes (WP):**
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.
NOTE: **Procedures cannot be deleted.** If a procedure has been entered in error or is invalid for some other reason, enter a results/diagnosis of 'Error/disregard'. Procedures with a results/diagnosis of 'Error/disregard' will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These procedures can be viewed only under the Patient Profile Including Errors option of the Manager's Patient Management menu.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Sec Results/Diagnosis:
This field stores a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

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[1] Patch WV*1*6 May 1999 Amended report
[2] Patch WV*1*6 May 1999 '+' sign if text present

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

(page 1 of 2):
Some procedures, such as colposcopy, cone biopsy, laser cone, and LEEP, will have a page 2 to the 'Edit a Procedure' screen. This is indicated by the words '(page 1 of 2)' on page 1. Page 2 is concerned with the clinical findings and tissue pathology results of colposcopy and similar procedures.

If there is no page 2 of data fields to be edited, then when you have completed the edits for this page you would save and exit this procedure via the command line at the bottom of the screen.

Page 2 – Colposcopy:

The clinical findings (for page 2) are usually found on a form used by the physician performing the colposcopy or biopsy. The tissue pathology report section would be used most commonly for colposcopies in which an ECC and a biopsy were performed at the same time as the colposcopy. Therefore, you will not need to add separate procedures for a biopsy and ECC if they are done with a colposcopy.

Screening PAP:
This field stores the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

WV EDIT PROCEDURE

Edit a Procedure

This option allows you to edit previously documented procedures for patients. The first prompt asks you to select an accession# or patient name. A patient's SSN may also be entered. An accession# would be of the form 'PS1998-24'. If you know the accession# of the procedure you wish to edit, it will be more efficient to select the procedure by its accession# rather than by its patient (some patients will have several procedures on file). Procedure data is stored in the WV Procedure (#790.1) file.

[1]NOTE: When a Radiology/Nuclear Medicine package exam is passed to the Women's Health package, an informational mail message is sent to the WH case manager.

Field Descriptions:

Page 1 - All Procedures:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

[1] Patch WV*1*7 October 1999 Info. message to case manager

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

[1]**Reports (WP):**
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words "AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

[2]**Notes (WP):**
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

[1] Patch WV*1*6 May 1999 Amended report
[2] Patch WV*1*6 May 1999 '+' sign if text present

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.
NOTE: **Procedures cannot be deleted.** If a procedure has been entered in error or is invalid for some other reason, enter a results/diagnosis of 'Error/disregard'. Procedures with a results/diagnosis of 'Error/disregard' will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These procedures can be viewed only under the Patient Profile Including Errors option of the Manager's Patient Management menu.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Sec Results/Diagnosis:
This field stores a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

(page 1 of 2):
Some procedures, such as colposcopy, cone biopsy, laser cone, and LEEP, will have a page 2 to the 'Edit a Procedure' screen. This is indicated by the words '(page 1 of 2)' on page 1. Page 2 is concerned with the clinical findings and tissue pathology results of colposcopy and similar procedures.

If there is no page 2 of data fields to be edited, then when you have completed the edits for this page you would save and exit this procedure via the command line at the bottom of the screen.

Page 2 – Colposcopy:

The clinical findings (for page 2) are usually found on a form used by the physician performing the colposcopy or biopsy. The tissue pathology report section would be used most commonly for colposcopies in which an ECC and a biopsy were performed at the same time as the colposcopy. Therefore, you will not need to add separate procedures for a biopsy and ECC if they are done with a colposcopy.

Screening PAP:
This field stores the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

[1]WV HS-USER DEFINED

Health Summary

This option allows the user to create a Health Summary report for a specific patient. The user may select multiple Health Summary components to create the health summary report.

The user selects a patient, then selects one or more Health Summary components such as Cytology or Surgical Pathology. The Health Summary components offer default values for the number of occurrences to return and time span to cover. For example, after selecting the Cytology component for display, the default values for time limit may be 1 year, and number of occurrences to display may be 10. This means the Health Summary package will search the lab database for Cytology tests from 1 year ago up to today. The 10 most recent tests will be displayed. The user may edit the default limits for each of the selected components at the "Select COMPONENT(S) to EDIT or other COMPONENT(S) to ADD:" prompt. After selecting one or more of the components, the user can then edit the default for number of occurrences to return at the "OCCURRENCE LIMIT:" prompt, and the default time span to cover at the "TIME LIMIT:" prompt. Also, a special "HEADER NAME:" may be assigned to the report output. The user is then asked to select a device.

[1] Patch WV*1*5 March 1999 New option

WV BROWSE PROCEDURES

Browse Procedures

This option allows you to search for and list procedures. The eight questions that are asked prior to the display allow you to specify patients, procedures, date range, status, normal/abnormal, case manager (site parameter), order of display, and device for the printout.

If the device selected for the 'Browse Procedures' display is 'Home' (to the screen), a column of numbers will appear to the left of the procedures. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Date:
This field contains the date the procedure was performed.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

WV PRINT A PROCEDURE

Print a Procedure

This option allows you to print information pertaining to a patient's procedure. You are prompted for an accession# or patient name, and for a device. The display/printout looks very similar to the 'Edit a Procedure' screen. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

These fields appear on the top of every page of the report:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field displays the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

Page 1:

Date of Procedure:
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Date First Entered:
This field displays the date on which this procedure record was first entered.

First Entered By:
This field identifies the name of the person who first entered data on this procedure.

[3]**Lab Accession#:**
This field displays the Laboratory package accession number for the procedure, if one exists.

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt
[3] Patch WV*1*7 October 1999 New field

Clinician/Provider:
This field displays the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Sec Results/Diagnosis:
This field displays a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

HPV:
This field displays the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Page 2 (for colposcopy only):

Screening PAP:
This field displays the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

Page 3 (for colposcopy only):

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

Page 4:

[1]**Notes:**
This is text describing the results/diagnosis of the procedure.

[1] Patch WV*1*6 May 1999 New field

WV ADD AN HISTORICAL PROCEDURE

Add an HISTORICAL Procedure

This option allows you to add procedures for a patient done in years past, in order to make her Patient Profile more complete. Only a minimum of data is required: date of procedure, procedure, results, HPV status and an optional health care facility.

If you wish to enter more of the data on a procedure from years past, you may of course add the procedure through the standard Add a NEW Procedure option. There is no requirement to add an old procedure under the Historical option. It is important, however, that current procedures be added under the Add a NEW Procedure option, where many more of the important and relevant fields are available for entering data. Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date:
This field contains the date that the procedure was performed.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

WV REFUSED PROC-ADD

Add a Refusal of Treatment

This option allows you to document a refusal of treatment if the patient declines to be treated at this treatment site for any reason. Refusal of treatment data is stored in the WV Refusals (#790.3) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

WV REFUSED PROC-EDIT

Edit a Refusal of Treatment

This option allows editing of an existing patient's refusal for treatment. The user must identify the record to be edited by entering a date that the treatment was refused or by selecting from a list of records in the WV Refusals (#790.3) file. Refusal of treatment data is stored in the WV Refusals (#790.3) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

WV ADD A NEW NOTIFICATION

Add a New Notification

This option allows you to add notifications for patients. A notification is a communication between the clinic staff and the patient.

When you add a notification, it must be given a type of notification. Most notifications are letters, however, they may also be phone calls, conversations, etc. The table below lists all of the types of notifications that are available in Women's Health:

CONTACT CHA	MESSAGE VIA PERSON
CONTACT PHN	MESSAGE VIA PHONE MACHINE
CONVERSATION WITH PATIENT	PHONE CALL, 1ST
LETTER, FIRST	PHONE CALL, 2ND
LETTER, SECOND	PHONE CALL, 3RD
LETTER, SECOND (CERTIFIED)	PROVIDER CONSULT
LETTER, THIRD (CERTIFIED)	

When you add a notification, it must also be given a purpose of notification. The purpose of notification is the reason the patient is being contacted. The table below lists the purposes of notification that come pre-loaded in Women's Health. It is possible to add other purposes of notification customized to your particular site, and to edit the ones listed below as well. (See Add/Edit a Notification Purpose & Letter option.)

COLP Abnormal, need further Tx
COLP follow up, PAP next month.
COLP follow up, next PAP 6 months.
DNKA Colposcopy (Did Not Keep Appt)
DNKA Colposcopy Follow Up
DNKA PAP routine
DNKA PAP asap
DNKA PAP urgent
MAM result normal, next MAM 1 year.
PAP abnormal, need colp 8-12 weeks PP.
PAP result abnl, rep PAP 3-6 mos.
PAP result abnormal, PAP 6 weeks P.P.
PAP result abnormal, next PAP 3 months and colp.
PAP result abnormal, schedule colposcopy.
PAP result normal, next PAP 1 year.
PAP result normal, next PAP 4 months.
PAP result normal, next PAP 6 months.

PAP, annual due.
PAP, follow-up due.
PREGNANCY Test NEGATIVE
PREGNANCY Test POSITIVE

Eventually, each notification should be given an outcome. The outcome of a notification describes the final result of the contact with the patient. The table below lists the outcomes that come pre-loaded in Women's Health. It is possible to add other outcomes customized to your particular site, and to edit the ones listed below as well. (See Add/Edit Notification Outcomes option.)

Chart Flagged
Declined Tx
MAM Normal letter sent
No known address
No response
PAP Normal letter sent
PHN referral
Patient Deceased
Patient left Service Area
Provider consult
Response not tracked
Scheduled appt for Colposcopy
Scheduled appt for PAP
Scheduled appt for Repeat PAP
Tx elsewhere
Unable to contact Patient

As stated above, this option allows you to add notifications for patients. The first prompt asks you to select a patient (either by name, or SSN). After you have selected a patient, the 'Edit a Notification' screen appears. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date Notification Opened (Required):
This field contains the date the notification was first created.

Facility (Required):
Select the health care facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the Print Queued Letters option, only letters associated with the user's facility will be printed. (The user's facility is the facility (also called 'Site' or 'Division') that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager or ADPAC.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing another clinic's letters.

Purpose of Notification (Required):
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

Priority:
Filled in automatically, based on the purpose of notification.

Type of Notification:
This field stores the method used to notify the patient from the choices available in the WV Notification Type (#790.403) file (e.g., letter, phone call, message, etc.).

Print Date:
Date letter is to be printed. Once the letter has a 'Print Date', it will print out on that date (or on any later date) when the option Print Queued Letters is run. For example, if the letter is queued to print on Friday but Print Queued Letters is not run until the following Monday, then the letter will print out with the Monday batch.

The default date that appears is based on whether the letter is a results letter or a reminder letter. If it is a results letter, the default date is 'Today'. If it is a reminder letter, the default date is based on the due date of the treatment need (breast or gynecologic) to which this purpose of notification relates. (See the Add/Edit a Notification Purpose & Letter option.)

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Printed:
Filled in automatically when the letter (if the notification is a letter) is printed.

Outcome:
This field stores the results or outcome, which may be a goal or an event, associated with this patient's notification.

Status:
Select either 'Open' or 'Closed'. A notification is usually left 'Open' until an outcome has been entered. If the notification is a results letter, it is usually closed when the letter is printed (no further outcome is expected). If the notification is a reminder letter (reminding the patient to call for a next appointment), it is usually closed either when the patient calls to schedule an appointment, or following the edit of her next procedure. (See 'The Basic Patient Management Loop'). A notification that is left 'Open' past its 'Complete by (Date)' will be displayed as 'Delinquent' on notification reports.

Patient Education:
Enter 'Yes' or 'No', depending on whether patient education occurred during the notification (for phone calls, conversations, etc.).

NOTE: If the notification is a letter and the letter has already been printed, most of the fields for that notification will be blocked from editing. This is to keep the data on the computer in sync with the letter that was sent to the patient. Only the bottom four fields (Complete by Date, Outcome, Status, and Patient Ed) will be editable.

After you leave the 'Edit a Notification' screen, if you did not save before exiting you will be asked 'Save changes before leaving form (Y/N)?', and if the notification was a letter, the program will ask, 'Do you wish to preview or print this letter now? Enter Yes or No: NO//'. 'Preview' allows you to look at the letter that has just been queued. To preview the letter, select 'Home' at the 'Device: ' prompt. 'Print' will print the letter immediately, regardless of its 'Print Date', and remove it from the queue of letters waiting to print. To print the letter immediately, select a printer at the 'Device: ' prompt.

If you answer 'No' to the 'Do you wish to preview or print this letter now?' prompt, the letter will remain in the queue, to be printed on its 'Print Date'. NOTE: These letters do not print automatically, the user should run the Print Queued Letters option to print the letters.

After the 'Edit a Notification' screen the program will ask, 'Do you wish to edit this patient's case data?'. Answer 'Yes' if you wish to update the patient's case data at this point. (See the Edit/Print Patient Case Data option in this chapter.)

WV EDIT NOTIFICATION

Edit a Notification

[1]This option allows you to edit a notification that already exists. You are first asked to select a patient (by name or SSN), and then a notification (by date or accession#). Once you have selected a notification to edit, the 'Edit a Notification' screen will appear. You may select another notification to edit before returning to the menu. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

[1] Patch WV*1*7 October 1999 Select another notification

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**Eligibility Code:**
This field contains the eligibility code of the patient.

[2]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date Notification Opened (Required):
The date the notification was first created.

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt

Facility (Required):
Select the health care facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the Print Queued Letters option, only letters associated with the user's facility will be printed. (The user's facility is the facility (also called 'Site' or 'Division') that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing one another's letters.

Purpose of Notification (Required):
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

Priority:
Filled in automatically, based on the purpose of notification.

Type of Notification:
This field stores the method used to notify the patient from the choices available in the WV Notification Type (#790.403) file (e.g., letter, phone call, message, etc.).

Print Date:
Date letter is to be printed. Once the letter has a 'Print Date', it will print out on that date (or on any later date) when the option Print Queued Letters is run. For example, if the letter is queued to print on Friday but Print Queued Letters is not run until the following Monday, then the letter will print out with the Monday batch.

The default date that appears is based on whether the letter is a results letter or a reminder letter. If it is a results letter, the default date is 'Today'. If it is a reminder letter, the default date is based on the due date of the treatment need (breast or gynecologic) to which this purpose of notification relates. (See the Add/Edit a Notification Purpose & Letter option.)

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Printed:
Filled in automatically when the letter (if the notification is a letter) is printed.

Outcome:
This field stores the results or outcome, which may be a goal or an event, associated with this patient's notification.

Status:
Select either 'Open' or 'Closed'. A notification is usually left 'Open' until an outcome has been entered. If the notification is a results letter, it is usually closed when the letter is printed (no further outcome is expected). If the notification is a reminder letter (reminding the patient to call for a next appointment), it is usually closed either when the patient calls to schedule an appointment, or following the edit of her next procedure. (See 'The Basic Patient Management Loop'). A notification that is left 'Open' past its 'Complete by (Date)' will be displayed as 'Delinquent' on notification reports.

Patient Education:
Enter 'Yes' or 'No', depending on whether patient education occurred during the notification (for phone calls, conversations, etc.).

NOTE: If the notification is a letter and the letter has already been printed, most of the fields for that notification will be blocked from editing. This is to keep the data on the computer in sync with the letter that was sent to the patient. Only the bottom four fields (Complete by Date, Outcome, Status, and Patient Ed) will be editable.

After you leave the 'Edit a Notification' screen, if you did not save before exiting you will be asked 'Save changes before leaving form (Y/N)?', and if the notification was a letter, the program will ask, 'Do you wish to preview or print this letter now? Enter Yes or No: NO//'. 'Preview' allows you to look at the letter that has just been queued. To preview the letter, select 'Home' at the 'Device: ' prompt. 'Print' will print the letter immediately, regardless of its 'Print Date', and remove it from the queue of letters waiting to print. To print the letter immediately, select a printer at the 'Device: ' prompt.

If you answer 'No' to the 'Do you wish to preview or print this letter now?' prompt, the letter will remain in the queue, to be printed on its 'Print Date'. NOTE: These letters do not print automatically, the user should run the Print Queued Letters option to print the letters.

After the 'Edit a Notification' screen the program will ask, 'Do you wish to edit this patient's case data?'. Answer 'Yes' if you wish to update the patient's case data at this point. (See the Edit/Print Patient Case Data option in this chapter.)

WV BROWSE NOTIFICATIONS

Browse Notifications

This option allows you to search for and browse through notifications. The six questions that are asked prior to the display allow you to specify patients, date range, status, case manager (site parameter), order of display, and device for the printout.

If the device selected for the 'Browse Notifications' display is 'Home' (to the screen), a column of numbers will appear to the left of the notifications. Notification data is stored in the WV Notification (#790.4) file.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Date:
This field contains the date the procedure was performed.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Priority:
This field associates a priority with the notification. The priority choices are: urgent, ASAP, and routine.

WV PRINT INDIVIDUAL LETTERS

Print Individual Letters

This option allows you to print individual letters. You are first asked to select a patient (by name or SSN), then a notification (by date or accession#), and then a printer device. The letter will print immediately (unless you queue it again), regardless of its 'Print Date', and then it will be removed from the queue of letters waiting to print. Letters are printed as needed by merging notification data (File #790.4) with a notification form letter (File #790.404).

WV PRINT QUEUED LETTERS

Print Queued Letters

This option allows you to print all letters that have been queued to print on the current date or on any date prior to the current date. Some of these letters may be reminder letters, put in the queue weeks or months earlier to print on this date, alerting the patient to call and schedule her next procedure (for example, an annual PAP). Others of these letters may be results letters queued earlier in the day to print today, informing the patient of results of a recent procedure. Only letters associated with your facility will be printed (see 'Facility'). Letters are printed as needed by merging notification data (File #790.4) with a notification form letter (File #790.404).

NOTE: The option to Print Queued Letters checks to see that the patient is not deceased. For a deceased patient, instead of the queued letter printing, an explanation is printed stating that the patient is deceased, that letter will not be printed, and that the notification has been closed and given an outcome of 'Patient Deceased'. At this time, the user should edit the deceased patient's case data and enter a date into the Inactive Date field. Refer to the Edit Patient Case Data explanation for additional information.

Chapter 5 Management Reports Menu

WV MENU-MANAGEMENT REPORTS

Management Reports

The Management Reports Menu contains options that provide program management reports and a limited set of epidemiological reports. The remainder of this section will briefly describe each of the options under the Management Reports Menu.

Menu Display:

```
Select OPTION NAME: WV MENU-MANAGEMENT REPORTS          Management Reports

   WOMEN'S HEALTH:          *  MANAGEMENT REPORTS  *          HINES DEVELOPMENT
                            ========================


   PS      Procedure Statistics Report
   SN      Snapshot of the Program Today
   RS      Retrieve/Print Earlier Snapshots
   CR      Compliance Rates for PAPs and MAMs
   BP      Browse Patients With Needs Past Due
   [1]ST    Sexual Trauma Summary Report
   [2]LST   List Sexual Trauma Data
```

[1] Patch WV*1*14 April 2001 Change in option name
[2] Patch WV*1*11 June 2000 Added option for MST

WV PRINT PROCEDURE STATS

Procedure Statistics Report

This option provides a report on the different women's health procedures performed at the facility. Data is broken down by veteran and non-veteran, and the numbers of procedures which have results of normal, abnormal, and no result. It also provides a count of patients who have had the respective procedures, whether or not they are veterans and if the results were normal, abnormal, or no result available. All results are also expressed as percentages.

This report first asks you for a date range, the group of procedure types to be included, if you wish to display statistics by age group, and a device. If you answer 'Yes' to display by age group you will be instructed to enter the age ranges you wish to select for in the form of: 15-29,30-39,40-105. Use a dash '-' to separate the limits of a range, use a comma to separate the different ranges. NOTE: Patient ages will reflect the age they were on the dates of their procedures. (Patient ages will NOT necessarily be their ages today.)

It is important to note that in the patient's section for each procedure type, the total may be less than the sum of the three results categories (normal, abnormal, and no result). This is because any individual patient may be included in all three categories of normal, abnormal, and no result. A patient may have received more than one procedure during the date range selected, and those procedures may have had differing results. Each results category simply gives the number of patients who fell into that category for the date range selected. The total, however, gives the total number of patients who received that procedure type for the date range selected, the report counts each patient only once, no matter how many times she may have had the procedure. For this reason, the total for the patients section may be less than the sum of the three results categories. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

The report displays a table sorted by procedure types and patients, listing the count, number of veterans and non-veterans, and the results of the procedures (normal, abnormal, and no result). Radiology credit (regular credit, no credit) is displayed for mammogram procedures.

WV BROWSE NEEDS PAST DUE

Browse Patients With Needs Past Due

This option is exactly the same as is found under the Patient Management Menu.

WV SEXUAL TRAUMA SUMMARY

[1]Sexual Trauma Summary Report

This option provides the user with a short report of the number of WH patients who have experienced sexual trauma in the military, as a civilian, or both. Civilian sexual trauma data is stored in the WV Patient (#790) file. Military sexual trauma data is stored in the MST History (#29.11) file.

NOTE: Patients who are deceased are not counted in this report.

Report Description:

This report can include Women's Health patients for one case manager or all case managers.

For each sexual trauma type (military or civilian), a table sorted by number of Veterans and Non-Veterans is displayed. These tables indicate the number of WH patients who have experienced sexual trauma in the military, as a civilian, or both.

[1] Patch WV*1*14 April 2001 Change in option name and description

[1]WV SEXUAL TRAUMA LIST

List Sexual Trauma Data

[2]This option displays a list of patients, their Civilian Sexual Trauma value from the WH package and the Military Sexual Trauma (MST) value from the MST module of the Registration package. The patient's name, SSN, case manager, age, veteran status and eligibility code are displayed, too.

Patients are sorted by case manager first, then MST status and finally patient name. The MST status order is:
1) Yes, Screened reports MST
2) No, Screened does not report MST
3) Screened Declines to answer
4) Unknown, not screened

Non-veteran patients are displayed after the veterans.

The user may choose to see the patients for one case manager or all case managers. Patients who are deceased or have an Inactive Date (prior to today's date) will not appear on the listing.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient. Pointer to the WV Patient (#790) file.

Case Manager:
This field contains the name of a WH case manager who is currently managing the women's health care needs of this patient.

[3]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

[1] Patch WV*1*11 June 2000 Added option for MST
[2] Patch WV*1*14 April 2001 Option description changed
[3] Patch WV*1*14 April 2001 WH prompt changed to MST prompt and CST prompt

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

Primary Care Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

Age:
This field contains the age of the patient.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

Eligibility Code:
This field contains the eligibility code of the patient.

Chapter 6 Manager's Functions Menu

WV MENU-MANAGER'S FUNCTIONS

Manager's Functions

The Manager's Functions Menu contains options that provide the ADPAC with a set of utilities for configuring the software to the specific needs of the site at which the Women's Health software is being used. It also provides utilities for other program needs, such as customizing letters, and making special edits to patient data.

The Manager's Functions menu contains many sensitive options requiring a thorough understanding of the software. The remainder of this section will briefly describe each of the options under the Manager's Functions Menu.

Menu Display:

```
Select OPTION NAME: WV MENU-MANAGER'S FUNCTIONS          Manager's Functions

   WOMEN'S HEALTH:        *  MANAGER'S FUNCTIONS  *         HINES DEVELOPMENT
                          ========================


   FM      File Maintenance Menu ...
   PQ      Print Queued Letters
   MPM     Manager's Patient Management ...
   LDE     Lab Data Entry Menu ...
```

WV MENU-FILE MAINTENANCE

File Maintenance Menu

The File Maintenance Menu is described in detail under Chapter 2. Please refer to that section for a complete description of the options under this menu.

Menu Display:

```
Select Manager's Functions Option: FM          File Maintenance Menu

   WOMEN'S HEALTH:       *  FILE MAINTENANCE MENU  *        HINES DEVELOPMENT
                         ============================


   AEP    Add/Edit a Notification Purpose & Letter
   PPL    Print Notification Purpose & Letter File
   ESN    Edit Synonyms for Notification Types
   OUT    Add/Edit Notification Outcomes
   ESP    Edit Site Parameters
   CM     Add/Edit Case Managers
   TR     Transfer a Case Manager's Patients
   PRD    Print Results/Diagnosis File
   ESR    Edit Synonyms for Results/Diagnoses
   PSR    Print Synonyms for Results/Diagnoses
   EDX    Edit Diagnostic Code Translation File
   PDX    Print Diagnostic Code Translation File
   RS     Add/Edit to Referral Source File
```

NOTE: The option Add Sexual Trauma Data to MST Module was added to this menu by patch WV*1*11 in June 2000, and then this option was removed by patch WV*1*14 in April 2001.

Chapter 8 Lab Data Entry Menu

WV MENU-LAB DATA ENTRY

Lab Data Entry Menu

This menu is used by laboratory personnel to add, edit and view procedures in the Women's Health database.

Menu Display:

```
Select OPTION NAME: WV MENU-LAB DATA ENTRY          Lab Data Entry Menu

   WOMEN'S HEALTH:           *  LAB DATA ENTRY  *           HINES DEVELOPMENT
                             ====================


   AP     Add(Accession) a NEW Procedure
   EA     Edit Accessioned Procedure
   EP     Edit a Procedure Result
   PR     Print a Procedure
   LOG    Display/Print Daily Log
```

WV LAB ADD A NEW PROCEDURE

Add(Accession) a NEW Procedure

This option is used by laboratory personnel to add procedures to the Women's Health database. Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

[2]**Eligibility Code:**
This field contains the eligibility code of the patient.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

[1] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt
[2] Patch WV*1*10 April 2000 Include eligibility code in heading

WV LAB EDIT ACCESSION

Edit Accessioned Procedure

This option is used by laboratory personnel to edit procedures in the Women's Health database. Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

[1]**MST:**
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) in the military. Set of codes: (Y = Yes, Screened reports MST; N = No, Screened does not report MST; D = Screened Declines to answer; U = Unknown, not screened).

"<N/A Not a Veteran>" is displayed for non-veterans.

CST:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) as a civilian. Set of codes: (Y = Yes, N = No, D = Declined to Answer, U = Unknown).

[2]**Eligibility Code:**
This field contains the eligibility code of the patient.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

[1] Patch WV*1*14 April 2001 Sexual Trauma prompt changed to MST prompt and CST prompt
[2] Patch WV*1*10 April 2000 Include eligibility code in heading

WV EDIT PROCEDURE

Edit a Procedure Result

This option is exactly the same as the Edit a Procedure option found under the Patient Management Menu.

WV PRINT A PROCEDURE

Print a Procedure

This option is exactly the same as is found under the Patient Management Menu.

WV LAB PRINT LOG

Display/Print Daily Log

This option displays a list and/or a total count of procedures recorded in the WV Procedure (#790.1) file.

The report output is based on criteria selected by the user including date range, type of procedure, facility, and procedures with no result/diagnosis or procedures with and without a result/diagnosis. The user may sort the list of procedures by accession number or patient name, or display a totals count only.

Report Description:

If a detailed report for each procedure is selected, the following information is displayed:

Date:
This field contains the date the procedure was entered into the database, or the date the procedure record was created.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Location:
This field contains the current ward location on which this patient is residing.

Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Date the Procedure was performed:
This field indicates the date the procedure was performed.

Entered by:
This field indicates the name of the person who entered data on this procedure.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Total Procedures:
This field indicates the total number of procedures performed.

Procedures without results:
This field indicates the number of procedures performed with no results.

Appendix B - Examples of Major Screen Edits

WV EDIT PATIENT CASE DATA

Edit/Print Patient Case Data

```
                    * * *  EDIT PATIENT CASE DATA  * * *


Patient Name: TEST,NANCY (49y/o)                      SSN: 088-88-8888
      Street: 1722 E 71ST PL                Patient Phone: 312-375-3743
  Cty/St/Zip: CHICAGO, IL  60649              Pr Provider: TEST,KEITH
    [1]Elig Code: SC LESS THAN 50%                 Veteran: YES
         [2]MST: No
_____________________________________________________________________________

      Case Manager: TEST,FRANK                   Inactive Date:
    Breast Tx Need: Mammogram, Screening      Cervical Tx Need: Routine PAP
Breast Tx Due Date: JUN 1,1998           Cervical Tx Due Date: JUN 1,1998
Breast Tx Facility: Hines                Cervical Tx Facility: Hines
       PAP Regimen: Pq6mx2, Pqy
PAP Regimen Start Date: JUN 1,1998                          [3]CST: Unknown
Family Hx of Breast CA: no family history             Notes (WP):
    Currently Pregnant: NO     EDC:                  DES Daughter: NO
 Date of 1st Encounter: MAY 18,1998                Referral Source: Provider
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


Do you wish to PRINT this patient's Case Data?
Enter Yes or No: NO// <RET>
```

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 MST appears in heading of the report
[3] Patch WV*1*14 April 2001 Sexual Trauma changed to CST

WV ADD A NEW PROCEDURE

Add a NEW Procedure

```
              * * *  WOMEN'S HEALTH: ADD A NEW PROCEDURE  * * *


Select PATIENT NAME: TEST,NANCY           02-28-49     088888888     YES
SC VETERAN
   Select PROCEDURE: PAP SMEAR// COLPOSCOPY W/BIOPSY       CO
   Select DATE:      TODAY// <RET>  (JUL 8, 1998)  JUL 8, 1998


 * Move to PAGE 2 to edit clinical and pathology findings.


                  * * *  EDIT A PROCEDURE  * * *
Patient Name: TEST,NANCY(49y/o)                        SSN: 088-88-8888
Case Manager: TRAXLER,FRANK                      Procedure: COLPOSCOPY
W/BIOPS
PAP Regimen : Pq6mx2, Pqy (began JUN 01,1998)         Acc#: CO1998-9
Cx Tx Need  : Routine PAP (by JUN 01,1998)     Cx Facility: Hines
Br Tx Need  : Mammogram, Scrn (by JUN 01,1998) Br Facility: Hines
[1]Elig Code   : SC LESS THAN 50%                     Veteran: YES
[2]MST         : No                                       CST: Unknown
-------------------------------------------------------------------------------
     Date of Procedure: JUL 8,1998
    Clinician/Provider: TEST,KEITH
  [3]Ward/Clinic/Location: EMPLOYEE HEALTH                    Reports (WP):
  Health Care Facility: HINES                                  Notes (WP):
              Comments:
    Complete by (Date): AUG 7,1998
     Results/Diagnosis: WNL/Normal                        HPV: YES
 Sec Results/Diagnosis:                                 Status: OPEN
                                                           (PAGE 1 OF 2)
_______________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND: N                                    Press <PF1>H for help
Insert
```

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma changed to MST and CST
[3] Patch WV*1*6 May 1999 Changed prompts

```
                  * * *  EDIT A PROCEDURE  * * *
Patient Name: TEST,NANCY(49y/o)                          SSN: 088-88-8888
Case Manager: TRAXLER,FRANK                        Procedure: COLPOSCOPY
W/BIOPS
PAP Regimen : Pq6mx2, Pqy (began JUN 01,1998)          Acc#: CO1998-9
Cx Tx Need  : Routine PAP (by JUN 01,1998)     Cx Facility: Hines
Br Tx Need  : Mammogram, Scrn (by JUN 01,1998) Br Facility: Hines
[1]Elig Code   : SC LESS THAN 50%                      Veteran: YES
[2]MST         : No                                        CST: Unknown
--------------------------------------------------------------------------------
         Screening PAP: PS1998-5
  T-Zone Seen Entirely: YES                          Multifocal: YES
  Lesion Outside Canal: YES                  Number of Quadrants: 2
     Satisfactory Exam: YES                   Quadrant Locations: UL,LR
            IMPRESSION:
         ECC Dysplasia: Not Done                        Margins Clear:
   Ectocervical Biopsy: Not Available                   Stage: I
        STD Evaluation: Negative                        (PAGE 2 OF 2)
________________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND: E                                      Press <PF1>H for help
Insert
```

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma changed to MST and CST

WV ADD A NEW NOTIFICATION

Add a New Notification

```
              * * *  WOMEN'S HEALTH: ADD NEW NOTIFICATION  * * *


Select PATIENT NAME: TEST,NANCY           02-28-49     088888888     YES
SC VETERAN



                     * * *  EDIT A NOTIFICATION  * * *
Patient Name: TEST,NANCY(49y/o)                          SSN: 088-88-8888
Case Manager: TRAXLER,FRANK                   Patient Phone: 312-375-3743
Cx Tx Need  : Routine PAP (by JUN 01,1998)    Cx Tx Facility: Hines
Br Tx Need  : Mammogram, Scrn (by JUN 01,1998)Br Tx Facility: Hines
PAP Regimen : Pq6mx2, Pqy (began JUN 01,1998)
[1]Elig Code   : SC LESS THAN 50%                        Veteran: YES
[2]MST         : No                                          CST: Unknown
--------------------------------------------------------------------------------
  Accession#: CN1998-5      Procedure: CONE BIOPSY

  Date Notification Opened: JUL 9,1998       Facility: HINES DEVELOPMENT
   Purpose of Notification: COLP Abnormal, need further TX
                  Priority: URGENT, RESULT
      Type of Notification: CONVERSATION WITH PATIENT   Print Date:
        Complete by (Date): AUG 8,1998                     Printed:
                   Outcome: Letter Canceled
                    Status: CLOSED                      Patient Ed: YES
________________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


Do you wish to PRINT this patient's Case Data?
Enter Yes or No: NO// <RET>
```

[1] Patch WV*1*10 April 2000 Include eligibility code in heading
[2] Patch WV*1*14 April 2001 Sexual Trauma changed to MST and CST

[1]Appendix C - Other Useful Information

To stop a background task before it has completed, you must:

1. Invoke the User's Toolbox [XUSERTOOLS] menu. It may be on the primary or secondary menu.
2. Select the TaskMan User [XUTM USER] option.
3. Enter the task number at the "Select Task:" prompt. If the task number is unknown, you can enter two question marks to see a list of your tasks. Find the task number from the list and exit the list display.
4. At the "Select Action (Task # nnnnnn):" prompt (where nnnnnn is the task number you selected) enter "Stop task".

The TaskMan utility will issue a message stating the outcome of your request.

[1] Patch WV*1*14 April 2001 New appendix

Glossary

Access Code A unique sequence of characters known by and assigned only to the user, the system manager and/or designated alternate(s). The access code (in conjunction with the verify code) is used by the computer to identify authorized users.

ADP Coordinator/ADPAC/Application Coordinator Automated Data Processing Application Coordinator. The person responsible for implementing a set of computer programs (application package) developed to support a specific functional area such as Women's Health, PIMS, etc.

Application A system of computer programs and files that have been specifically developed to meet the requirements of a user or group of users. Examples of V*IST*A applications are the PIMS and Women's Health application.

Archive The process of moving data to some other storage medium, usually a magnetic tape, and deleting the information from active storage in order to free-up disk space on the system.

ASAP Abbreviation for the phrase 'as soon as possible'.

Audit Trail/Logging Features The use of automated software procedures to determine if the security controls implemented for protection of computer systems are being circumvented and to identify the potential source of the security breach.

Backup Procedures The provisions made for the recovery of data files and program libraries and for restart or replacement of ADP equipment after the occurrence of a system failure.

Baud Rate The rate at which data is being transmitted or received from a computer. The baud rate is equivalent to the number of characters per second times 10.

Block The unit of storage transferred to and from disk drives, typically 512, 1024, or 2048 bytes (characters).

Boot The process of starting up the computer.

Bulletin A canned message that is automatically sent by MailMan to a user when something happens to the database.

Byte A unit of computer space usually equivalent to one character.

Case Manager The person who is currently managing the women's health care needs of a specific patient.

CIOFO Chief Information Office Field Office, formerly known as Information Resource Management Field Office, and Information Systems Center.

Contingency Plan A plan which assigns responsibility and defines procedures for use of the backup/restart/recovery and emergency preparedness procedures selected for the computer system based on risk analysis for that system.

CORE A collection of VA developed programs (specific to PIMS, Pharmacy Service, and Laboratory Service) which is run at VA Medical Centers.

CPU Central Processing Unit, the heart of a computer system.

CRT Cathode Ray Tube, similar to a TV monitor but used in computer systems for viewing data. Also called a Video Display Terminal (VDT).

CST Civilian Sexual Trauma.

Cursor A visual position indicator (e.g., blinking rectangle or an underline) on a CRT that moves along with each character as it is entered from the keyboard.

Data Dictionary A description of file structure and data elements within a file.

Device A hardware input/output component of a computer system (e.g., CRT, printer).

Disk A magnetic storage device used to hold information.

Edit Used to change/modify data typically stored in a file.

Field A data element in a file.

File The M construct in which data is stored for retrieval at a later time. A computer record of related information (e.g., Patient file).

File Manager or FileMan Within this manual, FileManager or FileMan is a reference to VA FileMan. FileMan is a set of M routines used to enter, edit, print, and sort/ search related data in a file; a data base.

Global An M term used when referring to a file stored on a storage medium, usually a magnetic disk.

Gynecologic Pertaining to the female reproductive tract.

Hardware The physical or mechanical components of a computer system such as CPU, CRT, disk drives, etc.

IRMS Information Resource Management Service.

Kernel A set of software utilities. These utilities provide data processing support for the application packages developed within the VA. They are also tools used in configuring the local computer site to meet the particular needs of the hospital. The components of this operating system include: MenuMan, TaskMan, Device Handler, Log-on/Security, and other specialized routines.

Kilobyte More commonly known as Kbyte or 'K'. A measure of storage capacity equivalent to 1024 characters.

LAYGO An acronym for Learn As You Go. A technique used by VA FileMan to acquire new information as it goes about its normal procedure. It permits a user to add new data to a file.

Legacy System An outdated system used for data storage and retrieval.

M Formerly known as MUMPS or the Massachusetts (General Hospital) Utility Multi-Programming System. This is the programming language used to write all V*IST*A applications.

MailMan An electronic mail, teleconferencing, and networking system.

MAM Abbreviation for Mammogram.

Megabyte A measure of storage capacity; approximately 1 million characters. Abbreviated as Mbyte or Meg.

Memory A storage area used by the computer to hold information.

Menu A set of options or functions available to users for editing, formatting, generating reports, etc.

Menu Manager A part of the Kernel that allows each site to manage the various options or functions available to individual users.

Modem An electronic device which converts computer signals to enable transmission through a telephone.

Module A component of the Women's Health software application that covers a single topic or a small section of a broad topic.

MST Military Sexual Trauma.

Namespace A naming convention followed in the VA to identify various applications and to avoid duplication. It is used as a prefix for all routines and globals used by the application. The Women's Health Package uses WV as its namespace.

Operating System The innermost layer of software that communicates with the hardware. It controls the overall operation of the computer such as assigning places in memory, processing input and output. One of its primary functions is interpreting M computer programs into language the system can understand.

Option A functionality that is invoked by the user. The information defined in the option is used to drive the menu system. Options are created, associated with others on menus, or given entry/exit actions. For example, the WVMENU is the main menu for the Women's Health application.

Package Otherwise known as an application. A set of M routines, files, documentation and installation procedures that support a specific function within V*IST*A (e.g., the ADT and Women's Health applications).

PAP Abbreviation for PAP smear.

Password A protected word or string of characters that identifies or authenticates a user, a specific resource, or an access type (synonymous with Verify Code).

Pointer A special data type of VA FileMan that takes its value from another file. This is a method of joining files together and avoiding duplication of information.

Port An outlet in the back of the computer into which terminals can be connected.

Printer A device for printing (on paper) data which is processed by a computer system.

Procedure Accession# A number assigned to represent a specific procedure performed on a specific patient on a certain date (e.g., PS1998-43).

Program A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Queuing The scheduling of a process/task to occur at a later time. Queuing is normally done if a task uses up a lot of computer resources.

Response Time The average amount of time the user must wait between the time the user responded to a question at the terminal and the time the system responds by displaying data and/or the next question.

Restart/Recovery Procedures The actions necessary to restore a system's data files and computational capability after a system failure or penetration.

<RET> Carriage return or Enter.

Routine A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Security Key A function which unlocks specific options and makes them accessible to an authorized user.

Security System A part of Kernel that controls user access to the various computer applications. When a user signs-on, the security system determines the privileges of the user, assigns security keys, tracks usage, and controls the menus or options the user may access. It operates in conjunction with MenuMan.

Sensitive Information Any information which requires a degree of protection and which should be made available only to authorized users.

Site Configurable A term used to refer to features in the system that can be modified to meet the needs of each site.

Software A generic term referring to a related set of computer programs. Generally, this refers to an operating system that enables user programs to run.

Subroutine A part of a program which performs a single function.

Task Manager or TaskMan A part of Kernel which allows programs or functions to begin at specified times or when devices become available. See Queuing.

Telecommunications Any transmission, emission, or reception of signs, signals, writing, images, sounds or other information by wire, radio, visual, or any electromagnetic system.

Terminal A device used to send and receive data from a computer system (i.e., keyboard and CRT, or printer with a keyboard).

UCI User Class Identifier. The major delimiter of information structure within the operating system.

User A person who enters and/or retrieves data in a system, usually utilizing a CRT.

Utility An M program that assists in the development and/or maintenance of a computer system.

VDT Video Display Terminal. Also called a Cathode Ray Tube (CRT).

Verify Code A unique security code which serves as a second level of security access. Use of this code is site specific; sometimes used interchangeably with a password.

V*IST*A Veterans Health Information Systems and Technology Architecture.

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